

CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 603

Department of Health &
Human Services

Center for Medicare &
Medicaid Services

Date: JULY 15, 2005

CHANGE REQUEST 3924

SUBJECT: Modification to the Appeals Language on the Medicare Summary Notice; Full Replacement of Change Request 3808

I. SUMMARY OF CHANGES: This Change Request (CR) fully replaces CR 3808, Modification to Appeals Language on Medicare Summary Notice, issued on April 29, 2005. This CR includes two new business requirements for carriers only. These new requirements correct an error in the previously issued business requirements (3808.3 & 3808.4). The new business requirements clarify the language proposed in CR 3808 to include fiscal intermediary and carrier only business requirements for the language that shall be used in the Appeals Information section of the MSN (English & Spanish versions). The purpose of this CR is to notify fiscal intermediaries, carriers, and DMERCs about modifications needed to the appeals language in the Medicare Summary Notice as a result of section 521, of BIPA, and sections 933, 939, and 940 of MMA.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : October 1, 2005

IMPLEMENTATION DATE : October 3, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:

R = REVISED, N = NEW, D = DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	21/10.3.8/Appeals Section
R	21/10.3.11/Back of MSN - Carriers and Intermediaries
R	21/20.6/Appeals Section
R	21/20.7.1/Carrier Spanish MSN Back
R	21/20.8/Intermediary Spanish MSN Back

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 603	Date: June 15, 2005	Change Request 3924
-------------	------------------	---------------------	---------------------

SUBJECT: Modification to the Appeals Language on the Medicare Summary Notice; Full Replacement of Change Request 3808.

I. GENERAL INFORMATION

A. Background: The Medicare claims appeal process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(a)(3)(c)(i) of the Act specifies that a request for a redetermination must be filed within 120 calendar days from the date the beneficiary receives the notice of the initial determination. In order to allow for adequate mailing time and delivery of the MSN, the cutoff date listed in the "Appeals Information" section of the MSN must be modified to include 5 additional days for delivery of the MSN to the beneficiary.

The purpose of this CR is to modify instructions provided to the contractors regarding the calculation of the appeal date listed in the "Appeals Information" section of the MSN and to provide additional clarification regarding the calculation of this date on the back page of the MSN.

B. Policy: The MSN shall be modified to allow beneficiaries up to 125 days from the date the MSN was issued (date listed on upper right hand corner of page 1 of the MSN) to request an appeal. This action is mandated by 1869(a)(3)(c)(i) of the Act, as amended by the BIPA.

NOTE: All MSNs printed on or after October 1, 2005, shall include the new language required by this CR, unless a contractor uses pre-printed MSN forms. Contractors that use pre-printed MSN forms may exhaust their existing stock before implementing these changes. However, contractors must ensure that they accept as timely, any appeal request from a beneficiary (or his/her appointed representative) that is filed within 5 days of the date specified on the MSN. This assumes that the beneficiary received the MSN 5 days after the date of the notice, unless you are given information that shows otherwise.

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)							
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers			
F I S S	M C S					V M S	C W F		
	Page 1 of the MSN.								

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)							
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers			
F I S S	M C S					V M S	C W F		
	None.								

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

<p>Effective Date*: October 1, 2005 Implementation Date: October 3, 2005</p> <p>Pre-Implementation Contact(s): Kathleen McCracken, kmccracken@cms.hhs.gov</p> <p>Post-Implementation Contact(s): Kathleen McCracken, kmccracken@cms.hhs.gov</p>	<p>No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2005 operating budgets.</p>
---	--

***Unless otherwise specified, the effective date is the date of service.**

10.3.8 - Appeals Section

(Rev. 603, Issued: 07-15-05; Effective: 10-01-05; Implementation: 10-03-05)

A. General Information About the Appeals Section

This section informs the beneficiary of his/her appeal rights. Print only Part B medical insurance language if only Part B information is on the MSN. Print only Part A information if only Part A information is on the MSN. Print both Part A and B appeals language side by side if both claim types are on the MSN.

B. Technical Specification

The following outlines the technical specifications for the Appeals section.

- The “Appeals Section” must be printed in its entirety. Display it at the bottom of the last page of the MSN if space permits. Otherwise, print it in its entirety at the top of the next page (which then becomes the last page).
- Print “Appeals Information - Part B” or “Part A,” whichever is applicable, equivalent to 14-point bold mixed case type flush left. The word “(Outpatient)” or “(Inpatient)” should follow Part B or Part A.
- Allow equivalent to 12-point blank line.
- *Fiscal intermediaries only, print, “If you disagree with any claims decision on either Part A or Part B of this notice, your appeal must be received by* (appeal date). Follow the directions below:” in equivalent to 12-point mixed case type, flush left.
 - “If you disagree with any claims decision *on either Part A or Part B of this notice,*” and the appeal date should be bold.
 - The appeal date is *125* days from the notice date on page 1 for Part B and *125* days from the notice date on page 1 for Part A. Date format is month, day, year (e.g., October 1, 1997).
- *Carriers only, print, “If you disagree with any claims decision on this notice, your appeal must be received by (appeal date). Follow the directions below:” in equivalent to 12-point mixed case type, flush left.*
 - *“If you disagree with any claims decision on this notice,” and the appeal date should be bold.*
 - *The appeal date is 125 days from the notice date on page 1 for Part B and 125 days from the notice date on page 1 for Part A. Date format is month, day, year (e.g., October 1, 1997).*

NOTE: Section 1869(a)(3)(C) of the Act eliminates the distinction between the time limits for requesting a Part A reconsideration and Part B review by creating a 120-day time limit for filing requests for appeal of all initial determinations. *This time limit is calculated based upon 120 calendar days from the date the beneficiary receives the MSN. For the purposes of calculating the receipt of the MSN, it is presumed that the beneficiary received the MSN 5 days after the date on the MSN, unless there is evidence to the contrary. Therefore, the cut off for the appeal date noted on the MSN shall be calculated based on 125 days from the notice date on page 1 of the MSN.*

- Allow equivalent to 12-point blank line.
- Format each of the following 3 lines by indenting 11 bytes:
 - Intermediaries number 1 through 3 each and skip 3 additional bytes;
 - Carriers print the number followed by the closed parenthesis and skip 2 additional bytes;
 - Allow equivalent to 12-point blank line between each printed line. Print all information equivalent to 12-point mixed case type. This information should only be shown once and centered if both Part A and B appeals language is shown. (See exhibit 1 in [§30](#).)

“1. Circle the item(s) you disagree with and explain why you disagree.

“2. Send this notice, or a copy, to the address in the “Customer Service Information” box on page 1. (You may also send any additional information you may have about your appeal.)

“3. Sign here _____ Phone number (____) _____.”

10.3.11 - Back of the MSN - Carriers and Intermediaries

(Rev. 603, Issued: 07-15-05; Effective: 10-01-05; Implementation: 10-03-05)

A. General Information about the Back of the MSN:

Print the appropriate information on the back of each page of the MSN. The information may be preprinted.

Print the back of the MSN at no more than 6 lines to an inch.

B. Technical Specifications for the Back of the MSN:

Contractors include the following information in this order:

- Title

Intermediaries: “IMPORTANT INFORMATION YOU SHOULD KNOW ABOUT YOUR MEDICARE BENEFITS,” centered as shown in exhibits in [§30](#) and printed equivalent to 14-point bold uppercase type in a band of 10-percent shading for MSNs showing both outpatient and inpatient information. (See [exhibit 2](#), “Back of Notice Outpatient and Inpatient Combined.”)

Carriers: “Important Information You Should Know About Your Medicare Part B Benefits,” centered and printed in 14-point bold uppercase type in a band of 10% shading.

- Allow equivalent to 12-point blank line.
- Subtitle/Statement.

Intermediaries and Carriers: “For more information about services covered by Medicare, please see your Medicare Handbook.” This subtitle is centered and printed equivalent 14-point mixed case type.

- Print horizontal line (0.048” wide extending from left to right margin).
- Allow equivalent to 12-point blank line.

Intermediaries:

Print the following information single-spaced in two newspaper style columns equivalent to 11-point mixed case type. Print the headings equivalent to 11-point bold uppercase type.

- Print a line down the center of the page dividing the two columns as shown in exhibit 2, “Back of Notice Outpatient and Inpatient Combined.”

- In the following paragraphs of exhibit 2, print the indicated words equivalent to 11-point bold type:
- Paragraph 2 - “The Amount You May Be Billed”; “Part A”; “an inpatient hospital deductible”; “a coinsurance amount for the 61st through 90th days”; “a coinsurance amount for each Lifetime Reserve Day”; “a blood deductible”; “an inpatient coinsurance for the 21st through the 100th days.” “skilled nursing facility”; “not covered”.
- Paragraph 4 - “annual deductible”; “Part B”; “coinsurance”; “not covered”.
- Paragraph 6 - “*120 days of the date you receive this notice*”; “help with your appeal”.

Intermediaries and Carriers:

- Allow blank line.
- Print horizontal line (0.048” wide extending from left to right margin).
- Print “Centers for Medicare & Medicaid Services” equivalent to 10-point bold italic type in a band of 10-percent shading.

Intermediaries must change the back of the MSN using the following language to reflect Outpatient Prospective Payment System (OPPS) changes in coinsurance.

"THE AMOUNT YOU MAY BE BILLED for Part B services includes:

- “**An annual deductible**, taken from the first Medicare Part B charges each year;
- “After the deductible has been met for the year, depending on services received, a **coinsurance** amount (20 percent of the amount charged), or a fixed copayment for each service; and
- “Charges for services or supplies that are **not covered** by Medicare. You may not have to pay for certain denied services. If so, a note on the front will tell you.”

Also, print the following message in the “General Information” Section:

“If the coinsurance amount you paid is more than the amount shown on your notice, you are entitled to a refund. Please contact your provider.”

Carriers must change the back of the MSN using the following language:

YOUR RESPONSIBILITY: The amount in the **You May Be Billed** column is your share of cost for the services shown on this notice. You are responsible for:

- **annual deductible:** taken from the first Medicare Part B approved charges each calendar year,
- **coinsurance:** 20% of the Medicare approved amount, after the deductible has been met for the year,
- the amount billed, up to the **limiting charge**, for unassigned claims, and
- charges for services/supplies that are **not covered** by Medicare. You may not have to pay for certain denied services. If so, a NOTE on the front will tell you.

*Carriers and fiscal intermediaries must change the back of the MSN in the “**YOUR RIGHT TO APPEAL**” section (located on the right hand column of the last page of the MSN) to read as follows:*

*“**YOUR RIGHT TO APPEAL:** If you disagree with what Medicare approved for these services, you may appeal the decision. You must file your appeal within **120 days of the date you receive this notice**. Unless you show us otherwise, we assume you received this notice 5 days after the date of this notice. Follow the appeal instructions on the front of the last page of the notice. If you want **help with your appeal**, a friend or someone else can help you. Also, groups such as legal aid services may provide free assistance. To contact us for the names and telephone numbers of groups in your area, please see our Customer Service Information box on the front of this notice.*”

20.6 - Appeals Section

(Rev. 603, Issued: 07-15-05; Effective: 10-01-05; Implementation: 10-03-05)

ENGLISH - Appeals Information - Part B

SPANISH - Información de Apelaciones - Parte B

Fiscal Intermediary Only ENGLISH - If you disagree with any claims decisions on either Part A or Part B of this notice, your appeal must be received by (_____). Follow the instructions below:

Fiscal Intermediary Only SPANISH - Si usted no está de acuerdo con cualquier decisión en la Parte A o la Parte B de esta notificación, debemos recibir su apelación antes de (_____). Siga las instrucciones indicadas abajo:

Carrier Only ENGLISH - If you disagree with any claims decision on this notice, your appeal must be received by (_____). Follow the instructions below:

Carrier Only SPANISH - Si usted no está de acuerdo con cualquier decisión en esta notificación, debemos recibir su apelación antes de (_____). Siga las instrucciones indicadas abajo:

ENGLISH - Circle the item(s) you disagree with and explain why you disagree.

SPANISH - Indique con un círculo los detalles con los que usted no está de acuerdo y explique la razón.

ENGLISH - Send this notice, or a copy, to the address in the Customer Service Information box on page 1. (You may also send any additional information you may have about your appeal.)

SPANISH - Envíe esta notificación o una copia a la dirección indicada en la sección Información de Servicios al Cliente en la página 1. (Usted también puede enviar cualquier información adicional que tenga sobre su apelación.)

ENGLISH - Sign here _____ Phone Number (____)_____

SPANISH - Firme aquí _____ Su número de teléfono (____) _____

20.7.1 - Carrier Spanish MSN Back

(Rev. 603, Issued: 07-15-05; Effective: 10-01-05; Implementation: 10-03-05)

The Spanish back should be printed using the same specifications as the English version but with the text below. Print the title of the Spanish back centered as shown in the exhibits in [§30.2](#) and printed in 14-point bold uppercase type in a band of 10-percent shading.

- INFORMACIÓN IMPORTANTE
- SOBRE SUS BENEFICIOS DEL SEGURO MÉDICO DE MEDICARE PARTE B
- Allow blank line.
- Subtitle: Centered and printed in 14-point mixed case type within the 10-percent shading.
- Para más información sobre los servicios cubiertos por Medicare, favor de ver su Manual de Medicare.
- Horizontal line (0.048" wide extending from left to right margin).

Print the following text single-spaced in two newspaper style columns using 11-point mixed case type. Print the headings in 11-point bold uppercase type. Print a line down the center of the page dividing the two columns as shown in exhibit 31.

- In the following paragraphs print the indicated words in 11-point bold type.
 - Paragraph 2 - "asignadas," "no asignadas", "asignación", "médicos participantes"
 - Paragraph 3 - "no asignadas"
 - Paragraph 4 - "usted puede ser facturado", "deducible anual", "\$100", "coaseguro", "cargo límite", "no están cubiertos"
 - Paragraph 6 - "120 días a partir de la fecha de este Resumen", "ayuda con su apelación"

SEGURO MÉDICO DE MEDICARE PARTE B: La Parte B de Medicare ayuda a pagar por servicios médicos, exámenes diagnósticos, servicios de ambulancia, equipo médico duradero y otros servicios de salud. El seguro de hospital (Parte A) ayuda a pagar por los servicios de hospitalización a pacientes en un hospital, servicios en una instalación de enfermería especializada seguido por una estadía en el hospital, servicio de cuidado de la salud en el hogar y cuidado de hospicio. Usted recibirá otra notificación si recibió servicios no asignados, servicios de la Parte A o servicios en una facilidad para paciente ambulatorio.

ASIGNACION DE MEDICARE: Las reclamaciones por servicios médicos, Parte B, pueden ser asignadas o no asignadas. Proveedores que aceptan la asignación acuerdan aceptar la cantidad aprobada por Medicare como pago completo. Medicare paga su parte de la cantidad aprobada directamente al proveedor. Usted podría ser facturado por la cantidad no cubierta por el deducible anual y el coaseguro. Usted puede comunicarse con

nosotros a la dirección o número de teléfono indicado la sección, “Información de Servicios al Cliente”, en la parte del frente de este Resumen para obtener una lista de médicos participantes, los cuales siempre aceptan la asignación. Usted puede ahorrar dinero escogiendo un médico participante.

Médicos que someten reclamaciones no asignadas no acuerdan aceptar la cantidad aprobada por Medicare como pago completo. Generalmente, Medicare le paga a usted 80% de la cantidad aprobada después de sustraer cualquier parte del deducible anual que usted no haya completado. Un médico que no acepta la asignación le puede cobrar hasta 115% de la cantidad aprobada por Medicare. Esto es conocido como el “Cargo Límite”. Algunos estados tienen límites de pagos adicionales. La sección de NOTAS en la parte del frente de esta notificación le dirá si su médico ha excedido el cargo límite y la cantidad correcta a pagar a su médico bajo la ley.

SU RESPONSABILIDAD: La cantidad que aparece en la columna “Podría Ser Facturado” es su responsabilidad monetaria por los servicios que aparecen en esta notificación Su responsabilidad:

- Deducible anual: los primeros \$100 de Medicare Parte B de cargos aprobados cada año;
- Coaseguro: 20% de la cantidad aprobada después de haber completado el deducible para ese año;
- La cantidad facturada hasta el cargo límite, por reclamaciones no asignadas, y
- Cargos por servicios/suministros que no están cubiertos por Medicare. Es posible que usted no tenga que pagar por ciertos de servicios denegados. Si este es el caso, una NOTA en la parte del frente, le indicará.

Si usted tiene un seguro suplementario, éste le podría ayudar a pagar estos cargos. Si usted usa esta notificación para reclamar beneficios suplementarios de otra compañía de seguros, haga una copia y guárdela en sus archivos.

CUANDO OTRO SEGURO PAGA PRIMERO: Todos los pagos de Medicare son hechos bajo la condición de que usted devuelva el pago a Medicare en caso de que los beneficios puedan ser pagados por un asegurador primario a Medicare. Los tipos de seguro que deberían pagar antes de que Medicare pague son: planes de seguro de salud patronal, seguro de no culpabilidad, seguro médico de automobiles, seguro de responsabilidad y compensación para trabajadores.

Notifíquenos inmediatamente si usted ha sometido o podría someter una reclamación al seguro primario antes que a Medicare.

SU DERECHO A APELAR: Si usted no está de acuerdo con la cantidad que Medicare aprobó por estos servicios, puede apelar la decisión. Debe someter su apelación dentro de **120 días a partir de la fecha en que recibió este aviso**. A menos de que demuestre lo contrario, asumimos que recibió este aviso 5 días después de la fecha de este aviso. Siga las instrucciones para apelar en la parte del frente de la última página de este aviso. Si

necesita ayuda con su apelación, un amigo o cualquier otra persona puede ayudarlo. También grupos tales como servicios legales le pueden proveer ayuda gratis. Para obtener los nombres y números de teléfonos de grupos en su área, comuníquese con nosotros, favor de ver la sección de Información de Servicios al Cliente en la parte del frente de este Resumen.

AYUDE A DETENER EL FRAUDE A MEDICARE: Fraude es una falsa representación de una persona o negocio para obtener pagos de Medicare. Algunos ejemplos de fraude son:

- Ofertas de mercancía o dinero a cambio de su Número de Medicare;
- Ofertas telefónicas o de puerta en puerta de servicios o artículos médicos gratis; y
- Reclamaciones sometidas a Medicare por servicios o artículos que usted no recibió;
- Si usted sospecha que una persona o negocio está envuelto en fraude, debe llamar a Medicare al Departamento de Servicios al Cliente, al teléfono indicado en la parte del frente de este notificación.

CONSEJERIA Y ASISTENCIA DE SEGURO: Todos los estados ofrecen Programas de Consejería y Asistencia de Seguro. Consejeros voluntarios pueden ayudarle libre de cargos con sus preguntas de Medicare, incluyendo inscripción, sus derechos, problemas de primas y seguros Medigap. Si usted desea más información, favor de llamarnos al número indicado en la sección de “Información de Servicio al Cliente”, en la parte del frente de este Resumen.

Allow blank line.

Horizontal line (0.048” wide extending from left to right).

Print Centers for Medicare & Medicaid Services in 10-point bold italic type on a band of 10-percent shading.

20.8 - Intermediary Spanish MSN Back

(Rev. 603, Issued: 07-15-05; Effective: 10-01-05; Implementation: 10-03-05)

The Spanish back should be printed using the same specifications as the English version. However, the font size is 10 points. Use the text provided in the Spanish MSN exhibit.

In the following paragraphs of exhibit 2 in [§30](#), print the indicated words in bold type. Where capitalized in this section, print in all capital letters.

Paragraph 1 - SEGURO DE HOSPITAL PARTE A (PACIENTE INTERNO), La cantidad por la cual usted podría recibir una factura incluye:

- un deducible de paciente interno en un hospital;
- una cantidad de coaseguro por los días 61 hasta 90;
- una cantidad de coaseguro por cada Día de Reserva Vitalicia;
- un deducible de sangre;
- un coaseguro de paciente interno por los días 21 hasta 100, facilidad de enfermería especializada;
- no están cubiertos.

Paragraph 2 - SEGURO MÉDICO PARTE B (PACIENTE EXTERNO), La cantidad por la cual usted podría ser factura incluye:

- **Un deducible anual**, los primeros \$100 de Medicare Parte B de cargos aprobados cada año,
- Después de que haya cumplido con el deducible, dependiendo de los servicios recibidos, **un coaseguro** (20% de la cantidad cobrada), o un **copago fijo** por cada servicio,
- Cargos por servicios/suministros que no están cubiertos por Medicare. Es posible que usted no tenga que pagar por ciertos cargos se servicios denegados. De ser el caso, una NOTA en la parte del frente le indicará.

Paragraph 3 - CUANDO OTRO SEGURO PAGA PRIMERO

Paragraph 4 - ***SU DERECHO A APELAR:*** *Si usted no está de acuerdo con la cantidad que Medicare aprobó por estos servicios, puede apelar la decisión. Debe someter su apelación dentro de **120 días a partir de la fecha en que recibió este aviso**. A menos de que demuestre lo contrario, asumimos que recibió este aviso 5 días después de la fecha de este aviso. Siga las instrucciones para apelar en la parte del frente de la última página de este aviso. Si necesita **ayuda con su apelación**, un amigo o cualquier otra persona puede ayudarle. También grupos tales como servicios legales le pueden proveer ayuda gratis. Para obtener los nombres y números de teléfonos de grupos en su área, comuníquese con nosotros, favor de ver la sección de Información de Servicios al Cliente en la parte del frente de este Resumen.*

Paragraph 5 - AYUDE A DETERNER EL FRAUDE A MEDICARE:

Paragraph 6 - CONSEJERIA Y ASISTENCIA DE SEGURO:

Also, print the following message in the "General Information" Section:

"If the coinsurance amount you paid is more than the amount shown on your notice, you are entitled to a refund. Please contact your provider."

Spanish Version:

"Si la cantidad de coaseguro que usted pagó es mayor que la cantidad que muestra su notificación, tiene derecho a un reembolso. Por favor comuníquese con su proveedor."